

**SUPPLEMENT TO THE "APPLICATION FOR BENEFITS"**  
**For Claims Under the Kentucky Assigned Claims Plan Only**

**TO: KENTUCKY ASSIGNED CLAIMS PLAN**  
**9200 Shelbyville Road Suite 605**  
**Louisville, Kentucky 40222**

**YOUR NAME** \_\_\_\_\_ **DATE OF ACCIDENT** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **TELEPHONE NO:** \_\_\_\_\_

As a result of injuries receive in the accident, did you receive and are you entitled to receive any benefits including but not limited to:

**A) Private Insurance?** Yes ( ) No ( )

If "Yes", check type: Health ( ) Group ( ) Auto ( ) Other ( )

**B) Government Benefits?** (County, State or Federal) Yes ( ) No ( )

If "Yes" type: Social Security ( ) Medicare ( ) Workmen's Comp ( ) Other ( )

**C) Other Gratuitous Benefits?** Yes ( ) No ( )

Wage continuation plans or other benefits (describe) \_\_\_\_\_

**D) Benefits Received From Any Other Source?** Yes ( ) No ( )

Name and Address of organization and amount: \_\_\_\_\_

**E) I am the owner of a motor vehicle.** Yes ( ) No ( )

If answer is "YES", specify the name of the insurance company, if the motor vehicle was insured at the time of the accident

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Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

You are required to provide this information in accordance with the KRS304.39-160. This supplement must be accompanied by the Application for Benefits form.

**Sign** \_\_\_\_\_

**Date** \_\_\_\_\_

**Witness** \_\_\_\_\_